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VOLUME 3

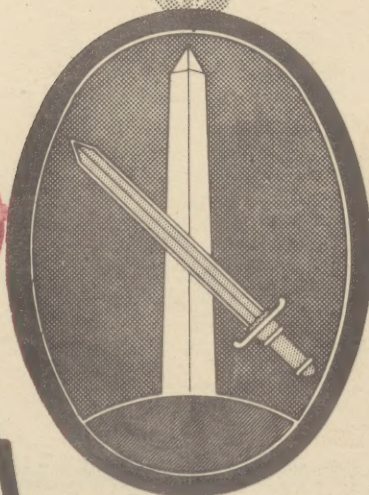
REPORT NO. 8

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# MONTHLY HEALTH REPORT

Military District of Washington

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## INTRODUCTION

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HEADQUARTERS, MILITARY DISTRICT OF WASHINGTON  
Room 1543, Building T-7, Gravelly Point  
Washington 25, D. C.







## INTRODUCTION

This publication presents periodic health data concerning personnel of the Department of the Army in the Military District of Washington. It provides factual information for measurement of increase or decrease in the frequency of disease and injury occurring at each of the posts, camps or stations shown herein.

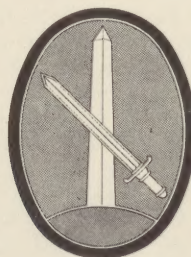
It is published monthly by the Military District of Washington for the purpose of conveying to personnel in the field current information on the health of the various military installations in this area and on matters of administrative and technical interest. Items published herein do not modify or rescind official directives, nor will they be used as a basis for requisitioning supplies or equipment.

Contributions, as well as suggested topics for discussion, are solicited from Medical Department personnel in the field.

ROBERT E. BITNER  
Colonel, MC  
Surgeon

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# VETERINARY SERVICE

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## VETERINARIANS' ROLE IN PUBLIC HEALTH

The veterinarians' role in the problems of public health is growing in all parts of the country and the science of veterinary public health is growing with it. Unless veterinarians put into practice the new developments in this science, they will not benefit the public nor will they improve the status of the veterinary profession. Outstanding figures in the profession have long contributed importantly to the public health and have improved the status of all the people of the United States and of the whole world. Among these can be listed Gamgee in Britain, Ostertag in Germany, Leonard Pearson in the United States, Salmon's great contributions to meat hygiene near the turn of the century, and many others that could be mentioned.

The problem of bovine tuberculosis is not solved in any country but this, and in several European nations the disease is under control.

Rabies and brucellosis are important diseases to health officers in every section of the United States. They will not be eradicated nor successfully controlled without the support of the veterinary profession and the participation of practitioners generally in the eradication programs.

Rabies is of vital concern to 500,000 persons in this country annually because that number are reported as having been bitten by dogs each year and 40,000 of them take the Pasteur treatment. We have the knowledge and the tools for the complete eradication of this disease. We should attack it on a national scale.

Control of the stray dog and the difficulty of that task has too long been stressed as essential to worthwhile accomplishment in the eradication. The stray dog is not the principal nor the most important factor in the spread of rabies. Comprehensive statistics in the southern states where the dog population is the most dense and the number of strays greatest, show that but 28% of the cases of rabies in dogs occur in strays, and these unwanted animals are responsible for an even smaller percentage of the bites inflicted on persons. Obviously the stray dog's opportunities for biting persons are not nearly so frequent as those of home dogs.

Community-wide vaccination of dogs will control rabies in this animal in any area. It is not possible to vaccinate all dogs in any extensive area, and fortunately it is not essential to the suppression of the disease. A good deal of experience has shown that 100% vaccination is not necessary, as rabies cannot perpetuate itself if 70% of the dogs in a given community are immunized. It may be a coincidence, but this same percentage of immunes will prevent or suppress outbreaks of diphtheria and whooping cough among children. Of course, the goal should be set at 70% vaccination. We should probably seldom attain either it or eradication if we set our goal so low. The aim should be complete immunization of the dog population and if we fail to attain it, we still shall conquer the disease. At the same time, we should employ all other useful, practicable means of preventing infected dogs from biting susceptible animals, such as confining dogs to the owners' premises, permitting dogs at large only on leash, collecting and destroying strays, etc., and in this way hasten the victory over rabies.

In some parts of the country the wild animal reservoir of rabies infections is important. The red fox is a prolific spreader of rabies, particularly to cattle. All along the Appalachian mountains from New York to Georgia this animal is a common source of rabies infection in domestic animals. Formerly, 800 cases of rabies in dogs occurred in New York state in a single year. By an intensive campaign, that number was reduced so that last year there were only four cases of the disease in dogs. The cases in foxes increased so rapidly that there were 1,000 known infections in foxes in the same period. In handling rabies in wild animals, the conservation authorities should be called upon for assistance. Experience in Georgia and other southeastern states has shown that the conservation forces can reduce the fox or other wild animal population at one-third the cost that we can, with sufficient reduction in numbers for eradication of the disease among these animals. Since the fox is not a gregarious animal, the disease will not be perpetuated among them except where they occur in large numbers, so when the density of the fox population is reduced sufficiently, there is a spontaneous disappearance of the disease from among these animals.

## BRUCELLOSIS

Brucellosis is another important public health problem, the solution of which is mainly a responsibility of veterinarians. Only milk from brucellosis-free herds should be permitted to be



## VETERINARY SERVICE

sold as grade A. The ring test recently introduced in this country gives great promise as a means of locating infected herds quickly and inexpensively. Information as to its whereabouts is essential in the control or eradication of any disease. If further use of the ring test lives up to preliminary promises, it will be a tremendous help in the eradication of brucellosis.

Brucellosis is the no. 1 occupational disease of veterinarians. Eradication of it will improve the health of veterinarians and of the public, and at the same time increase the agricultural prosperity.

### TRICHINOSIS

The trichinosis incidence rate in the United States is the highest in the world. An extensive investigation begun by the late Dr. Maurice C. Hall and continued by Dr. Willard Wright of the Zoological Division of the U. S. Public Health Service, an investigation that included hundreds of autopsies on the cadavers of persons who had died of all manner of ailments, revealed that 18% of them had at some time during their lives been infected by the *Trichinella*. The high incidence of trichinosis in this country is due to eating the flesh of garbage-fed swine. Every veterinarian and public health authority knows this and the public should be equally informed. Garbage feeders and their allies have attributed the infection of swine to eating rats harboring the *Trichinella*, but many tests in which dead rats were mixed with garbage and fed to swine have shown that in nearly all cases, the hogs have eaten the garbage and rejected the rat carcasses. Rarely could a hog be induced to attempt to eat a rat and even then he usually gave it up as a bad job. It has been claimed that swine catch and eat rats that are feeding with them, but it has not been explained how a pig can catch an agile rat, nor has it been demonstrated that it occurs or is possible.

Veterinarians should do all they can to discourage feeding of raw garbage. Entirely aside from its public health value, a law to make illegal the feeding of raw garbage to any animal designed to be used for human food would promote the prosperity of the swine industry by decreasing the spread of hog cholera and other diseases of swine, which are frequently spread by contaminated raw garbage.

### OTHER DISEASES OF PUBLIC HEALTH INTEREST

Among the newest problems of veterinary public health are those posed by swine influenza, hydatid disease and Queensland (Q) fever.

Q fever was first discovered in Montana 13 years ago. Seven years ago the virus was discovered in dead ticks at the Hamilton Montana Laboratory where vaccine is produced for the prevention of Rocky Mountain spotted fever. Since the close of the war, outbreaks of Q fever have been recognized in persons, the first in this country among packing house employees at Amarillo, Texas. Later, the disease occurred over a wide area in southern California, chiefly among persons associated with cattle--dairyman and dairy employees, cattle feeders, etc. The disease is subclinical in animals and of no economic importance to animal husbandry, but it causes a virus pneumonia in persons. The means by which it is spread are not known, but it is thought to be mainly by inhalation. The placenta is a rich source of the virus in infected cattle. Infected sheep eliminate the virus principally in the feces.

Recently, *Salmonella* infection has been discovered to occur in dogs to an extent of from 2.5% in strays, where the incidence is lowest, to 95% in Greyhound kennels where it is the highest so far determined. Many of the infected animals are carriers and many spasmodic cases of diarrhea in dogs, formerly attributed to other causes, are now recognized to be canine salmonellosis. Some severe outbreaks, running through all the dogs in a kennel or in a veterinary hospital have occurred. As in man and other animals, the principal symptom of salmonellosis in dogs is a more or less severe, acute diarrhea.

An informed veterinary profession and educated citizenry are essential to the solution of the veterinary public health problems that now confront us. Putting into effect the proper control measures will improve the health of our nation and improve its agricultural economy.

Notes from a paper on the Veterinarians' Role in Public Health, presented by J.H. Steele, D.V.M., M.P.H. Chief, Veterinary Public Health Division, U.S. Public Health Service, Atlanta, Georgia, at the 68th annual meeting of the Illinois State Veterinary Medical Association, Peoria, Feb. 1-3, 1950.



# VETERINARY SERVICE

## RABIES-HYDROPHOBIA

Rabies-hydrophobia is a neurotropic disease and is acquired through inoculation only. A dog is bitten, inoculated by a rabid animal. The inoculated virus travels from the wound along the nerve fibers and trunk to the brain or spinal cord. There in the great network of nerve-tissue it multiplies rapidly, produces the disease and overflows through the salivary glands into saliva. The virus of rabies is filterable through porcelain by pressure and suction. It can be fed by mouth or injected subcutaneously, intramuscularly, intraperitoneally or intravenously by means of a small caliber smooth sharp needle, without producing the disease. If on the other hand, a large barbed pointed needle be used in making injections, through these same routes, infection may occur because of the tissue damage. Here we have trauma and disruption of nerve fibers opening the path for nerve tissue infection. When the suspension of virus is injected directly into the brain the resultant disease is a certainty.

This experimental evidence indicates that the connective tissue and myelin sheaths of nerve fibers offer a barrier against rabies virus invasion of nerve tissue. So then the axon protoplasm of nerve fibers appears to be the soil favorable for the propagation and active extension of the virus. The invasion of this protoplasm occurs only when the insulating coverings are disrupted.

Thus in a bite by a rabid animal, the skin, subcutaneous tissues, blood vessels, lymph channels, fascia, muscle tissue are broken and nerve fibers are disrupted. The rabies virus of the implanted saliva must have entrance to the insulated nervous system in order to produce the disease; this takes place only when the virus has contact or continuity with the axon protoplasm of disrupted or severed nerve fibers. Here we have a typical inoculation disease of the nervous system from an outside source: the bite of a rabid animal.

In rabies, the disease is propagated by transmission of the virus from the diseased animal to a susceptible one by the inoculating bite. In rabies among those bitten and not treated, the disease develops in only about 15% of the cases.

In rabies, transmission is direct from the sick animal by inoculation of the virus laden saliva to the susceptible one. The virus in the brain and spinal cord multiplied beyond the saturation point overflows into the saliva and having been introduced into a wound in a susceptible animal the life cycle is completed only if the virus makes contact with the protoplasmic core of a disrupted nerve fiber. Here the saliva is only a passive carrier of the virus, the vehicle through which it is transported from brain tissue of a rabid animal to disrupted peripheral nerve fibers of a susceptible animal.

Rabies is strictly a neurotropic infection and by necessity for propagation it must be an inoculation disease. There must be severed nerve fibers to provide entrance to nerve tissue. This is a biological requirement for its survival.

The incubation period in rabies is from a couple of weeks to several months. Those bitten on the face in close proximity to the brain have the shorter incubation period, while extremity inoculations have the longer.

The above is extracted from an article entitled "Poliomyelitis-An Hypothesis of Its Etiology" by James G. Cumming, M.D. Dr PH, Director, Bureau Preventable Diseases, Department of Health, Washington, D. C. "Military Surgeon" - August 1950.



# PREVENTIVE MEDICINE

## SUMMARY OF IMMUNIZATION REQUIREMENTS

### a. Routine immunizations required for all military personnel

Agent	Number of doses	Initial series		Stimulating doses	
		Individual dose	Interval between doses	When indicated	Amount
Smallpox vaccine	1	Contents 1 capillary tube.	---	Every 3 years; within 1 year prior to departure for overseas areas; and in presence of the disease.	Contents 1 capillary tube.
Typhoid-paratyphoid vaccine	3	1st dose, 0.5 cc; 2d dose, 0.5 cc; 3d dose, 0.5	7 to 28 days	Annually, and in presence of the disease	One dose, 0.5cc. subcutaneous or 0.1 cc Intracutaneous
Tetanus toxoid (plain)	3	Each dose, 1.0 cc	Minimum of 21 days	One year after initial series, every 4 years after last stimulating dose and upon occurrence of wounds or burns, as directed by the medical officer.	1.0 cc
(Alum precipitate).	2	0.5 cc	4 to 8 weeks		

### b. Immunizations required for travel to certain overseas areas (In addition to routine immunizations)

Agent	Number of doses	Initial series		Stimulating doses	
		Individual dose	Interval between doses	When indicated	Amount
Typhus vaccine *	2	1.0 cc each	1 week	At 4 to 6 month intervals in presence of danger of epidemic (louse-borne) typhus.	1.0 cc
Cholera vaccine	2	1st dose, 0.5 cc; 2d dose, 1.0 cc	1 week	At 4 to 6 month intervals in presence of danger of cholera	1.0 cc
Yellow fever vaccine*	1	0.5 cc of the proper dilution	---	Every 4 years, if in yellow fever endemic area	0.5 cc of the proper dilution.
Diphtheria toxoid (plain)	4	0.1, 0.5, 1.0, 1.0 cc	2 days between 1st & 2d; 3 to 4 weeks for remainder.	If Schick reaction becomes positive; usually not required.	1.0 cc, in divided doses if necessary.

### c. Immunizations employed only on special indications

Agent	Indication	No. of doses	Initial series		Stimulating doses	
			Individual doses	Interval between doses	When indicated	Amount
Influenza vaccine*	As prescribed by The Surgeon General in anticipation of outbreak of influenza A or B.	1	1.0 cc	---	As prescribed by The Surgeon General	1.0cc
Japanese B encephalitis vaccine.*	As prescribed by The Surgeon General in anticipation or presence of outbreak	2	1.0 cc	7 to 10 days	One month after completion of initial series	1.0cc
Plague vaccine	Only if prescribed in orders or in presence of definite plague hazard	2	1st dose, 0.5cc, 2d dose, 1.0 cc	1 week	At 4- to 6-month intervals in presence of danger of plague.	1.0cc.
Rocky Mountain spotted fever vaccine.*	Only for personnel exposed frequently to ticks in infected areas.	3	1.0cc	1 week	Annually if exposed	1.0cc.



# PREVENTIVE MEDICINE

Agent	Indication	No. of doses	Initial series		Stimulating doses	
			Individual doses	Interval between doses	When indicated	Amount
Immune serum globulin	Prevention or modification of measles in susceptible contacts under special conditions.	1	5 to 10 cc within 10 days after exposure	-----	Usually none	-----
Tetanus antitoxin	Wounded personnel who have not received initial toxoid series	1	Not less than 1,500 units	-----	Usually none	-----
Rabies vaccine	When bitten by rabid animal	14 or 21	See directions on package	1 day	None	-----

\*These vaccines produced by culture of viruses in embryonated eggs. See paragraph 3 for warning against administration of egg vaccines to persons who may be sensitive to egg proteins.

Oversea areas, for travel to or through which special immunizations are required for military and civilian personnel and dependents.

Area	Typhus fever	Immunization against-		
		Cholera	Yellow fever	Diphtheria
Europe, including British Isles	See note 1	-----	-----	See note 2
Africa	X	-----	See note 3	See note 2
Asia	X	X	-----	See note 2
Japan, Korea	X	X	-----	See note 2
Philippine Islands, Ryukyus	-----	X	-----	See note 2
Central and South America	See Note 1, Not required for Panama.	-----	See note 3 Required for Panama	See note 2
Egypt	-----	X	-----	

Legend: X indicates immunization required for travel to area specified.

## NOTES

1. Typhus immunization is required for travel to the following countries in the Western Hemisphere: Mexico, Guatemala, Colombia, Ecuador, Peru, Bolivia, and Chile. Individuals traveling to Europe whose destinations are known to be east of 18° E. longitude will be immunized against typhus fever.

2. Diphtheria immunization, or a Schick-negative status, is required for all military and civilian personnel and dependents proceeding to the European or Mediterranean Theater if under the age of 35 years. All dependents under the age of 15 years, proceeding to an oversea area, are required to be immunized or Schick negative.

3. Yellow fever immunization is required for travel to or through all endemic areas indicated below. This vaccination must have been accomplished at least 10 days before departure from the United States if travel is to be through an endemic area en route to a nonendemic area. The definition of international yellow fever endemic areas as formulated by the Expert Commission on Quarantine of UNRRA is given below in abridged form:

a. In Africa. (1) Northern boundary--from mouth of River Senegal along that river eastward to the 15° N. parallel of latitude; thence eastward along that parallel to northwestern boundary of Eritrea; thence northward along Eritrean boundary to Red Sea coast.

(2) Southern boundary--along 10° S. parallel of latitude from western coast of Africa to eastern border of Belgian Congo; thence along this border, the southern border of Uganda Protectorate and the southern border of Kenya Colony to the Indian Ocean.

(3) The Barotze Province in Northern Rhodesia and the islands of the Gulf of Guinea are also included in the area, the Port of Massawa in Eritrea is excluded.

b. In South America. From Pacific coast at 5° N. parallel of latitude east along that parallel to eastern slopes of Central Cordillera to an elevation of 2,000 meters; thence southward along eastern slopes of Central Cordillera and Andes Mountains at the same elevation to boundaries of Argentina and Bolivia; thence eastward and northward along southern and eastern boundaries of Bolivia to 15° S. latitude; thence eastward along that parallel to western border of State of Goiaz in Brazil; thence northward along that boundary and western boundary of State of Maranhao to Atlantic coast; thence along Atlantic and Caribbean coast of South America to eastern boundary of Canal Zone; thence southward across Isthmus of Panama and along Pacific coast to 5° N. parallel of latitude. The area also includes the Ilheos and Halbuna Districts in the State of Bahia in Brazil. It excludes the following ports and cities: Belem in Brazil, Cayenne in French Guiana, Paramaribo in Surinam, Georgetown in British Guiana, Caracas in Venezuela, and Bogota in Colombia; and the Caribbean ports of Colombia and Venezuela.

Note. All airports in South America regularly visited by Air Transport Command Planes are outside the yellow fever endemic area. Yellow fever vaccination is required for travel to the Panama Canal Department; personnel traveling into regions of the Isthmus classed as endemic areas will be vaccinated in the Department.

The above is reproduced from TB MED 114, as changed.

It is suggested that pages 4 and 5 be placed in medical installation immunization rooms.

# CLEARING COMPANY OF MEDICAL BATTALION

## CLEARING COMPANY OF THE MEDICAL BATTALION, INFANTRY DIVISION

1. **GENERAL.** The function of the clearing company is to operate one or more clearing stations for the treatment of all casualties suffered in the division. This primary function resolves into the following:

- a. The reception of casualties brought to the clearing station.
- b. The sorting of these casualties according to the nature and severity of their injuries.
- c. The administration of appropriate treatment to save lives, reduce suffering, and prevent permanent disability.
- d. The temporary care and shelter of casualties until such time as their physical condition permits further evacuation or return to duty.
- e. The return of slightly injured to duty.
- f. The preparation of appropriate medical records.
- g. The operation of a dispensary for treatment of personnel of the medical battalion when the division is not engaged in combat.
- h. The performing of interior guard duty for the battalion, sharing his duty with the ambulance company.

### 2. COMPANY HEADQUARTERS.

a. The company headquarters is organized to perform the functions of command, administration, mess, supply, and motor maintenance. Certain medical reports are required of unit surgeons. The clearing company commander (or one of his assistants) may be designated by battalion headquarters to prepare such reports as necessary. The company commander (Major, MC) is assisted by an officer of the Medical Service Corps, a first sergeant, and a company clerk. Included in the personnel of company headquarters is a Medical Corps officer whose primary duty is assistant division neuro-psychiatrist. The supply sergeant, mess steward, motor sergeant, cooks, mechanics, drivers, and fillers (basics) complete the headquarters personnel.

b. Company headquarters establishes a command post of the clearing station. When more than one station is established, the company headquarters will remain with one of the stations. Personnel, such as cooks and supply clerks, will be divided between them.

3. **CLEARING PLATOON.** Normally each clearing platoon has three medical officers (the senior to whom is the platoon commander) and one Medical Service Corps officer, certain noncommissioned officers, and a large number of technicians, all provided for the primary purpose of operating a clear station. It should be borne in mind that the function of the clearing platoons are largely professional, and only a small amount of administrative work is necessary.

### 4. CLEARING STATION.

a. **Location.** The clearing station is the last element in division (second echelon) medical service. The general location is determined in the medical plan of the battalion prepared by the battalion commander and approved by the division commander on recommendation of the division surgeon and the G-4 of the division staff. The exact location is determined by the clearing company commander who makes a ground reconnaissance. He, or the platoon commander, determines the location of each department of the station. Depending on the tactical situation, the station is desirably located from four to ten miles from the front lines. It must be on, or very near, a road on the route of evacuation from the collecting stations at the front and hospitals in the rear. An available water supply is desirable. A central location in the division rear area is preferable but not as important as other considerations inasmuch as vehicles are used for transportation.

b. **Establishment.** A clearing station may be set up in tents or in existing buildings and is arranged into departments for the administration and treatment of casualties. Usually one or



# CLEARING COMPANY OF MEDICAL BATTALION

two stations are established initially and the other established at such time and place as circumstances of battle demand. When it becomes necessary for one station to move its location because of a changing tactical situation, one station must remain in operation until the first has become established at its new site. Should three platoons be committed so that each operates a clearing station in support of a respective regimental combat team, a station will then split internally and move forward by leap-frogging. It is contemplated that one of the platoons may be used as a rest station for those in the division who suffer battle fatigue. The number of tents set up will depend upon the flow of casualties; no more should be set up than necessary. Normally the tents should be compact, in the open, and each marked with a Geneva Cross for air identification. There should be an additional large Geneva Cross placed on the ground. Dispersion and concealment of large medical units, such as clearing stations, is impractical and rarely necessary. Some departments and sections that may be set up in the establishment of a clearing station are as follows:

(1) Record Section. Each clearing station must maintain a complete record of every patient treated in the station. The disposition of every patient is essential to the records and reports made by the division adjutant general and G-1. Ordinarily, each clearing station in operation will prepare an admission and disposition sheet giving name, serial number, organization, date of admission, complete diagnosis, and disposition of each patient admitted to the station. The Clearing Station Tag is not a standard Medical Department Form and its use is only a suggested method to aid in the preparation of the admission and disposition sheet. The procedure for using this tag is explained in subsequent paragraphs of this lesson.

## (2) Receiving Department.

(a) Casualties are admitted at the receiving department, examined, and sorted according to their injuries. As soon as classified, patients are removed to the proper department for treatment, or, if necessary, to a place where they can be cared for while awaiting treatment. Casualties should be sent to treatment departments in order according to urgency of their condition; not in order of their arrival at the station. Ordinarily, a Medical Service Corps officer is designated as admitting officer.

(b) The admission clerk fills out, in part, the Clearing Station Tag using an imprinting machine for the name and serial number. The bottom section of this tag (section A) is torn off and sent to the record section. The top section of the tag (section B) is fastened to a button of the wounded soldier's uniform, and remains with him until he has been treated and is ready for further evacuation or return to his organization.

(c) The Emergency Medical Tag is completely filled out including the casualty's organization, location where first tagged, and disposition. If a soldier arrives without a tag, one is initiated for him.

(d) A supply of litter, splints, and blankets is maintained at the front of the receiving department for property exchange with the ambulances. This property exchange is supervised by the supply department. Arms and equipment that may accompany patients are taken up and turned over to the supply department for proper disposition. Valuables in possession of patients ordinarily are not taken from them in a clearing station, but every effort is made to safeguard them.

(e) In combat, the treatment departments will often be overtaxed, and space must be set aside in the receiving department for patients awaiting their turn. One man is assigned to their care. It is his duty to keep in contact with the treatment departments, informing them of the number and condition of cases awaiting treatment, and performing such services as will add to the comfort of the waiting casualties.

(f) Two litter squads ordinarily are required in the receiving department, one to unload ambulances and the other to remove patients to the proper department for treatment.

## (3) Seriously Wounded Department.

(a) This department consists of an operating section and a shock section in two squad tents that may be joined together end to end. The medical officer of the clearing platoon best qualified in surgery should be in charge of this department.

# CLEARING COMPANY OF MEDICAL BATTALION

(b) Operating Section. Here may be performed any necessary surgical operation. The Surgical equipment available permits rather elaborate surgery on cases necessitating it, but one must bear in mind that the clearing station is a mobile installation and must be so kept. Further, the department cannot become immobilized by devoting an undue amount of time to one casualty at the expense of other casualties awaiting surgery. The decision as to what surgical procedure will be performed on a given case will be indicated by the need for that procedure, the number of casualties awaiting treatment, and the possibility of evacuating the casualty within a reasonable time post-operatively.

(c) Shock Section. Patients arriving at the clearing station in a condition of shock are sent immediately to the shock section unless some operative treatment (control of hemorrhage) is imperative at once. Likewise, all casualties in shock after treatment at one of the other departments must be sent here. All personnel in the platoon must be trained to recognize shock and to anticipate its occurrence so that prophylactic treatment can be instituted promptly. The shock section should be supervised by a competent technician well trained for his assigned duties.

(4) Slightly Wounded Department. This department should be supervised by a medical officer and all casualties admitted to it must be examined by him. However, much of the dressing can be done by competent technicians. This department prevents the seriously wounded department from becoming clogged with slightly wounded cases while serious cases need immediate treatment.

(5) Dental Department. This department is operated by a dental team from headquarters and headquarters company. Soldiers with mouth and jaw injuries, particularly fractured jaws, should be sent to this department.

(6) Gas Treatment Section. This is set up only when necessary and should be in a separate tent isolated somewhat from the rest of the clearing station. If gas casualties are numerous, the department may be reinforced by the attachment of gas teams from a professional service unit.

(7) Wards. One or more tents are used as wards for the care of sick and injured who cannot be evacuated immediately because of poor physical condition or whose treatment and ultimate return to duty can be accomplished within the time prescribed by the division evacuation policy, the tactical situation permitting.

(8) Dispensary. When in battle, casualties suffered by personnel of the medical battalion are evacuated in the same manner as any other casualty. When not in combat, however, the clearing station must operate a dispensary for their routine medical care and treatment.

(9) Supply Department. Each clearing platoon operates a department for the storage of platoon property and for equipment salvaged from casualties passing through the station. Ammunition, hand grenades, and rifle grenades are removed from the patient at the battalion aid station. Rifles and other arms are removed from the casualty at the collecting station; however, some casualties with this equipment may arrive at the clearing station. The equipment is held at the clearing station until collected by the division ordnance company.

(10) Mess Section. One mess section is established for personnel of the clearing company and for its patients. If the clearing platoons are separated, the mess section may be divided so that each platoon operates its own mess. Patients, able to walk, get their own food; others have it taken to them.

(11) Forwarding Department. After a casualty has been treated and prepared for further evacuation or return to duty, appropriate entries are made upon his Emergency Medical Tag and his Clearing Station Tag. He is then sent to the forwarding department. Here the top section of the Clearing Station Tag (section B) is removed from his person and sent to the record section where all such tags are consolidated and used to compile the admission and disposition sheet. (It will be recalled that the bottom section (section A) was filled out, detached, and sent to the office at the time of admission.) The noncommissioned officer in charge of this department supervises the care of casualties awaiting evacuation, the loading of ambulances, property exchange, and the disposition of cases other than those evacuated. He sends back to the proper treatment department such cases as develop further need of treatment while awaiting disposition. One or two litter squads are required to remove patients from the treatment departments and to load ambulances. Slightly wounded are returned to duty.



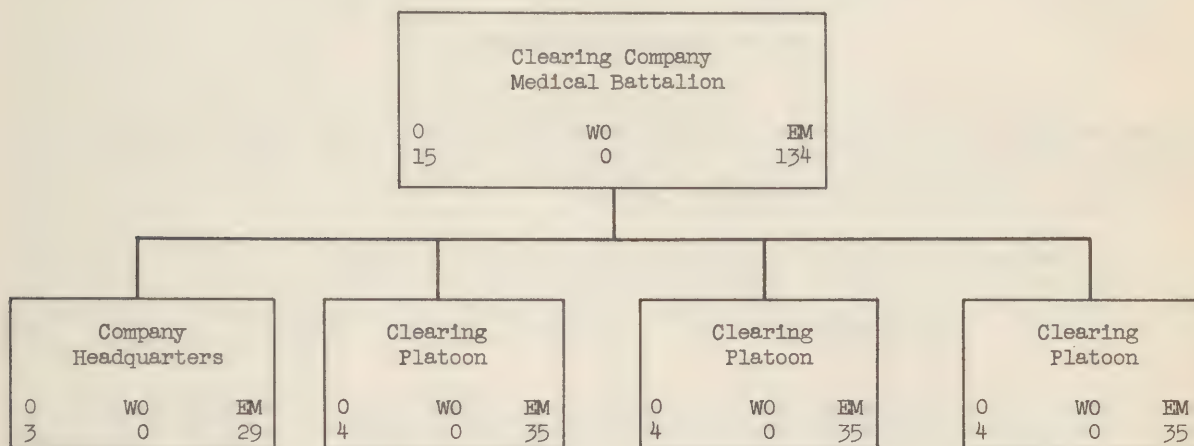
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## CLEARING COMPANY OF MEDICAL BATTALION

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(a) Morgue. Patients who die at the clearing station should be placed in a site somewhat removed from other departments so they will not be visible. If this is not done promptly, a marked depressive effect will be made upon other personnel. The dead are held at the morgue until removed for burial in accordance with a plan prescribed by G-4 of division headquarters. This is a function of the Quartermaster Corps. The principal concern of medical personnel is to assure that each body is tagged with an FMT properly filled out.

### ORGANIZATION OF THE CLEARING COMPANY



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## PREVENTIVE MEDICINE

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### PREPARATION OF PART IX, COMMUNICABLE DISEASES, OF W.D., M.D., FORM 86ab

1. One of the most important purposes of the Statistical Health Report is to furnish current information on the incidence of communicable diseases. W.D., M.D. Forms No. 52 are completed too late for this purpose. The following specific uses are made of data from part IX of the Statistical Health Report:

- It provides knowledge of the trend of incidence of diseases, such as common respiratory diseases, diarrheal diseases, pneumonia, measles, mumps, and scarlet fever.
- It makes possible comparisons of rates between individual post, tactical units, service commands, and overseas forces.
- It furnishes information on outbreaks of less common conditions which constitute a threat to the health of the command (examples: bacterial food poisoning, meningitis, coccidioidomycosis, encephalitis, and poliomyelitis).
- It permits early investigation of diseases important because of their relationship to the Army's immunization program or because of their epidemiological implications (examples: smallpox, typhoid fever, tetanus, typhus fever, and Rocky Mountain spotted fever).
- Based upon the information obtained from these reports and from occasional telegraphic or telephonic communications from the field, epidemiological investigations are instituted and measures for control initiated, special inquiries on certain diseases made, summaries of incidence rates compiled for use in connection with control programs, and other steps taken.

2. It is important that the reporting of communicable diseases be as accurate and complete as possible. It is recognized that the time allotted for preparation of these forms before submission to The Surgeon General is very brief, and that with the present shortage of medical officers,

## PREVENTIVE MEDICINE

much of the work in their preparation must be done by nonmedical officers and by enlisted personnel. Hospital registrars, however, will supervise the work of other personnel closely enough to insure reasonable completeness and accuracy in reporting; the surgeon of the command will maintain close liaison with the registrar's office. It is recommended that the Chief of Communicable Diseases, Medical Service, be made responsible for the accuracy of diagnoses reported. In some instances, the admission diagnosis is hastily made and may be changed within 24 to 48 hours after admission. When the change is made before the closing date of the report, the revised diagnosis rather than the admission diagnosis will be entered in the Statistical Health Report. The recording of a diagnosis will not, however, be postponed beyond the closing date of the report period merely because it cannot be definitely determined. Full cognizance is taken of the shortcomings of the date reported in this manner for diagnoses such as common respiratory or diarrheal disease.

### USE OF NEEDLES AND SYRINGES

The use of unsterile needles and/or syringes to administer parenteral injections or to collect blood specimens may result in the transmission of infections of various kinds including homologous serum jaundice. While the virus of the latter disease is relatively resistant to many of the usual bactericidal agents, heat will destroy it and hence the disease, as well as other types of infection, is readily preventable by suitable precautions.

All instruments, including needles, syringes, lancets, and rubber tubing used for injections or for the collection of blood specimens must be sterile. Sterilization by dry heat or autoclaving is preferable and is strongly recommended. However, where this is impracticable, instruments may be sterilized by boiling for a minimum of five minutes. The only exception to this rule is outlined for skin puncture below.

In addition to the use of sterile instruments, certain technical procedures will aid in the elimination of the hazard of transmitted infections. For this reason, the rules described below should be routinely observed.

a. Skin puncture to obtain blood for blood counts, hemoglobin determinations, etc.

(1) Hollow needles and "automatic lancets" will not be used since blood clots in the lumens cannot be sterilized by alcohol.

(2) Lancets, solid needles, or knife blades used for skin puncture should be carefully wiped off after each use and immersed continuously in 70 percent alcohol until reused.

b. Venipunctures for collecting blood specimens.

(1) Only sterile syringes and needles may be used since, otherwise, small amounts of infectious material may find their way into the vein by reflux when the tourniquet is removed prior to withdrawal of the needle. If syringes and needles are sterilized by boiling, they must be dry when used.

(2) Bleeding with the sterile needle only is considered to be the most practicable technique when large numbers of specimens are to be taken as for serologic tests. The attachment of a short piece of rubber tubing to the hub of the needle is permissible if the tubing is sterilized before each use and is dry.

(3) Accidental contamination of needle shafts must be avoided.

c. Parenteral injections.

(1) For intravenous or intramuscular injections, individual heat-sterilized syringes must be used. No syringe or needle should be reused until after resterilization.

(2) For immunization of groups of individuals, it is permissible to use 5 or 10 cubic centimeter syringes until empty. However, a fresh sterile needle must be used for each individual. When emptied, the syringe must be resterilized before reuse. If at any time blood or tissue fluid is aspirated into the syringe, including its hub, the syringe and its contents must be discarded.

(3) For intracutaneous injections, the use of individual sterile needles with multiple injections from the same syringe is permissible.

### TRAINING

Arrangements should be made for every Medical Department soldier and officer to pass through the infiltration course and gas mask drill chamber when facilities are established. Rosters should be checked monthly for new arrivals and those who have not been recently indoctrinated.



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# PROFESSIONAL SERVICES

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## PROFESSIONAL ROUNDS AND MEETINGS IN HOSPITALS

1. GENERAL: In order to foster high standards of professional practice, staff rounds and medical meetings should be regularly conducted in all hospitals. Such gatherings furnish officers with essential opportunities to share, mutually, and to examine, critically, current professional experience, in order that they may profit by the study of diagnostic, prognostic, and therapeutic successes and failures. Staff meetings should also facilitate the dissemination of newer knowledge in all fields of medicine. It is desirable that all professional members of the staff participate frequently in both presentations and discussions. An effort should be made to break down the barriers between the various professional services, including the laboratory service. The subject matter and presentation should be fresh, lively, and stimulating, as well as instructional. The proceedings should be informal rather than formal. The frequency of meetings should not be so great as to cause poor attendance or to interfere with other duties. The following paragraphs discuss briefly the professional activities referred to herein.

2. STAFF ROUNDS: Under the leadership of the chief of service, his deputy, or an appropriate visiting officer or civilian doctor, staff rounds should be held once a week on each major clinical service. These rounds should be additional to those made by the chief of service or his deputy for the purpose of general supervision of the various parts of his service, at which, as a rule, only officers immediately concerned should be present. In general, all officers assigned to a service should attend staff rounds of their service. On these occasions, a limited number of selected cases which pose unusual problems or are especially instructive should be presented and discussed in detail. It is often desirable that officers from other services (including the laboratory) than that to which the patient is assigned should take part. Care should be taken to bear in mind at all times the possible effects of both presentation and discussion upon the patient.

3. STAFF MEETINGS: A general meeting of the professional staff under the rotating leadership of the chiefs of the professional services, including the laboratory service, should be held once a week. The program for these meetings should be flexible so as to bring within their scope as many as possible of the different types of professional meetings which it may be necessary or desirable to hold. Some of the important varieties of subject matter which should be included are mentioned below.

a. Articles and addresses on all sorts of professional subject, including moving picture demonstrations, should be given by members of the staff, and by appropriate visiting officers or civilian doctors.

b. Current medical experience at the post, elsewhere in the Medical Department, and in civil life, should be surveyed from time to time, especially with reference to the noneffective rate, morbidity and fatality rates, length of hospitalization, and types of disposition, both in general and for important specific diseases and injuries. All deaths in the hospital should be discussed.

c. Clinical cases should be presented from time to time, especially those of considerable interest to more than one service and those in connection with which unusual studies or procedures have been performed.

d. Clinical pathological conferences should be held for the presentation and correlation of clinical and anatomical findings. Cases should be derived from the hospital's own experience and, if possible, from other sources, such as the Army Institute of Pathology, and the series presented in the New England Journal of Medicine. In addition, all officers should attend as many as possible of the post-mortem examinations made at the hospital.

e. Administrative problems, new directives and other official publications should be presented and clarified.

4. USE OF LIBRARY: The use of medical books and especially medical journals in the hospital library is a measure of the liveliness of the professional interest of the staff. To encourage it, the library should be conveniently located, freely accessible, comfortably furnished, and well maintained. The conditions for the withdrawal of books and journals for a limited period of time should be liberal.

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## PROFESSIONAL SERVICES

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5. CIVILIAN MEDICAL MEETINGS: As far as practicable and within the necessary limits of military duties, the attendance of Medical Department officers at civilian medical meetings and their participation of the proceedings at such meetings should be encouraged.

The above article from TB MED 210, 10 Dec 45.

### THE BURN PROBLEM IN ATOMIC WARFARE

#### I. Emergency Management of the Burn Patient

##### A. Five details highly important

1. Relief of pain.
2. Emergency dressing.
3. Prevention and treatment of shock.
4. Salt and water requirements to insure adequate urinary output.
5. The most feasible antibiotic therapy to aid in the prevention of infection.

##### 1. Pain:

Use morphine (.015 gm) or codeine (.060 gm). Prompt adequate covering of burn. Avoid general anesthesia.

##### 2. Emergency dressing:

Closed dressing - infrequently changed. (Cleansing of the burn with mild soap and water or detergents will be impossible to perform in the treatment of large numbers of burn patients. It is evident that unless cleansing of the burn wound can be done carefully under ideal conditions, more harm than good is accomplished). (Locally applied antibiotics is controversial).

##### 3&4 Prevention and Treatment of Burn Shock:

Adequate transfusion with plasma and/or whole blood. Less than 20% body burned, little or no plasma necessary if fluids can be taken by mouth. Offer fluids regularly. 20 - 35% body surface burned requires 1 - 2 liters plasma first 24 hours; 1/2 - 1 liter second 24 hours. Sodium - containing solutions must be given intravenously in 3 - 5 liter amounts daily. 35% and more would require large amount of blood and plasma and great amount of medical care. Insure adequate hourly output of urine; this is a good simple procedure.

##### 5. Antibiotic Therapy:

Penicillin is a most effective antibiotic agent for prevention and treatment of infection in mass casualties at present.

Aureomycin may prove to be of value for those burn patients who have been exposed to large amounts of gamma and neutron radiation.

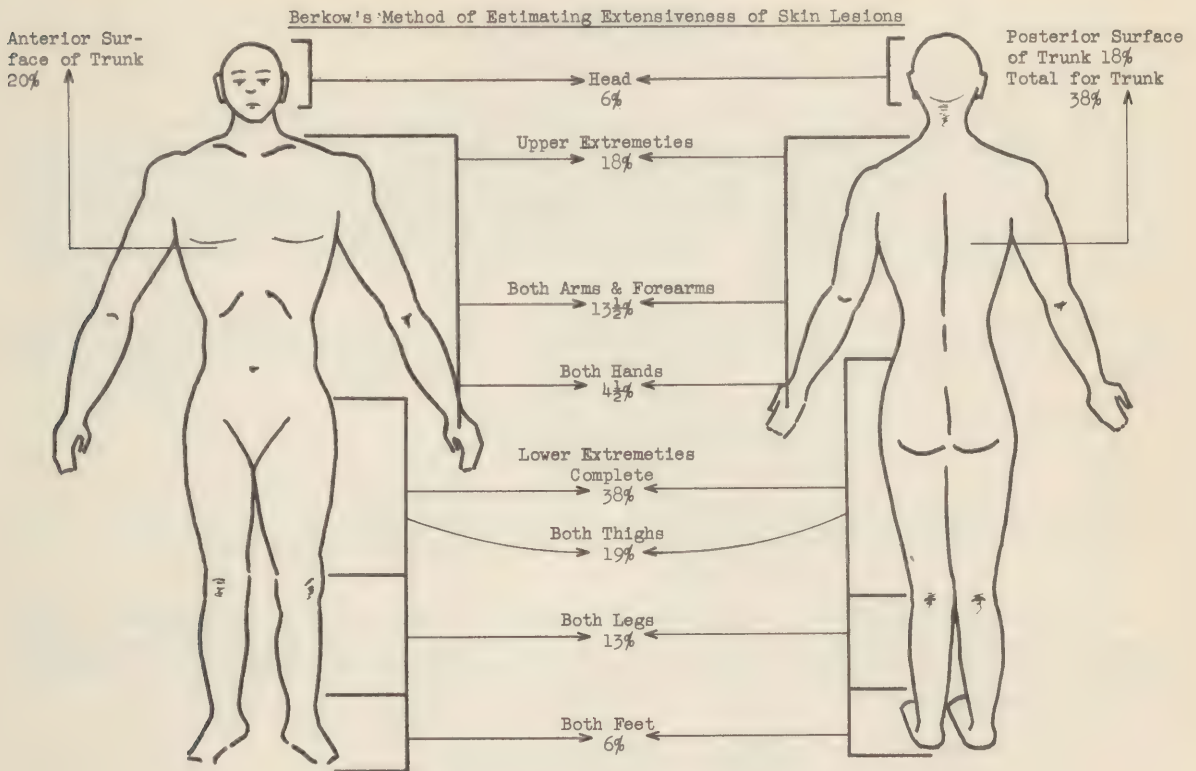
#### II. Trained Personnel

Adequate numbers of trained personnel to administer morphine, penicillin, blood, plasma, and dress burns are imperative.

A simple chart for computing burn area is reproduced on page 13.



## PROFESSIONAL SERVICES



### DISPOSITION OF EXPOSED X-RAY FILMS

A study regarding the disposition of exposed medical X-ray films was completed recently by the three armed services, and has been submitted to the Administrator of Veteran Affairs for concurrence. It is contemplated that exposed X-ray films will be authorized for salvage or for transfer to the Veterans Administration after five (5) years' retention at medical installations. Pending the publication of comprehensive disposition instructions for exposed X-ray films, it is desired that exposed X-ray films be retained at medical installations.

The foregoing in no instance changes the disposal standards as prescribed in SR 345-920-1.

### RED CROSS BLOOD CERTIFICATES

The Red Cross provides a certificate on which is stated the blood type and RH determination for each person who donates blood to the Blood Donor Centers. Here is an opportunity for the communities to have blood type of individuals determined in advance of any catastrophe at the same time the individual is rendering a service to his country.

### SECURITY

Safe combinations must be changed every six months or upon the transfer of the responsibility for the safe. New combinations must be on file. Army regulations and post regulations should be consulted for details.

## PREVENTIVE MEDICINE

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### GENERAL COMMENT

The health of the command continued to be excellent.

Unless otherwise indicated, reference to disease and injuries in this publication applies to all Class I and Class II installations exclusive of Walter Reed Army Hospital. Rates are calculated on the basis of a thousand mean strength per year. Statistics presently reported by Army medical installations do include those Air Force personnel who are treated or hospitalized at the reporting unit on a casual basis, since reciprocal use of other service's medical installations is made. Air Force statistics are tabulated separately for units having Air Force personnel assigned. (See General Data and Admissions Tables on page 15)

The non-effective rate\* increased from the June rate of 11.44 to 11.86 for the month of July. Days lost as a result of disease and injury totaled 5,814 during the four week period ending 28 July 1950.

\*Non-Effective Rate --  $\frac{\text{Total Days lost} \times 1,000}{\text{No. of Days Average Daily in Period} \times \text{Strength}}$

Non-effective rates indicate the average number of patients in hospital or quarters per thousand mean strength during the report period.

The total admission rate\*\* for disease and injury in July was 342.6, compared to 381.8 during June. Total admission for disease and injury in July was 460. Of this number, 409 admissions were for disease and 51 for injuries. Fort Myer reported the highest admission rate, and US Army Dispensary, The Pentagon, reported the lowest rate during the current month.

\*\*Admission Rates --  $\frac{1,000 \times 365 \times \text{Number of Cases}}{\text{Mean Strength} \times \text{No. of Days in Period}}$

Admission rates show the number of cases per thousand strength that would occur during a year if cases occurred throughout the year at the same rate as in the report period

July's rate for disease cases is 304.6 for 409 cases. Fort Myer reported the highest admission rate, and US Army Dispensary, The Pentagon, reported the lowest rate for disease cases.

An injury admission rate of 38.0 per 1,000 per annum for July was reported. This was a decrease from the June rate of 43.4. Fort McNair reported the highest rate and South Post, Fort Myer, reported the lowest rate for injuries.

There was one death reported during the four week period ending 28 July 1950, by units within the Military District of Washington less Walter Reed Army Hospital.

### COMMUNICABLE DISEASE

Common respiratory diseases decreased in incidence during the month of July, 1950. The rate for the present month is 85.6 compared to the June rate of 104.5. Fort Belvoir reported the highest rate, and US Army Dispensary, The Pentagon, reported the lowest rate. Admission rates for pneumonia (all types) declined during the July report period. The rate being .7 compared with the June rate of 1.2. There were no cases of scarlet fever reported through the month of July.

No appreciable change was noted in the rate for mumps, tuberculosis, rheumatic fever, diarrheal disease, and hepatitis during the four week period ending 28 July 1950.

Pertinent statistical tables may be found on pages 16 and 20.

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# PREVENTIVE MEDICINE

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GENERAL DATA  
4-week Period Ending 28 July 1950  
(Date from WD AGO Forms 8-122)

	MEAN STRENGTH			DIRECT ADMISSIONS						Non-Effective Rate	Number of Deaths
	Total	White	Negro	All Causes		Disease		Injuries			
				Cases	Rates	Cases	Rates	Cases	Rates		
Fort Belvoir (A)	8,530	7,502	1,325	237	362.2	206	314.8	31	47.4	9.54	1
(AF)	180	169	11	9	651.8	6	434.5	3	217.3	20.63	-
Fort McNair (A)	791	722	69	25	412.0	20	329.6	5	82.4	13.95	-
(AF)	19	19	0	0	-	0	-	0	-	-	-
Fort Myer (A)	1,419	1,238	181	73	670.6	62	569.5	11	101.1	15.28	-
(AF)	0	0	0	0	-	0	-	0	-	-	-
South Post, Fort Myer (A)	1,603	1,603	0	44	357.8	44	357.8	0	-	16.46	-
(AF)	0	0	0	0	-	0	-	0	-	-	-
US Army Dispensary (A)	3,476	3,441	35	44	165.0	41	153.8	3	11.2	17.15	-
The Pentagon (AF)	3,620	3,584	36	73	262.9	71	255.7	2	7.2	13.26	-
All Others (A)	1,684	1,684	0	37	286.4	36	278.7	1	7.7	4.50	-
(AF)	114	114	0	2	228.7	2	228.7	0	-	7.52	-
Total Mil Dist of Wash (A)	17,503	15,893	1,610	460	342.6	409	304.6	51	38.0	11.86	1
(AF)	3,933	3,886	47	84	278.4	79	261.8	5	16.6	13.37	-
AMC - Med Det (Duty Pers)*	1,818	1,677	141	67	480.4	63	451.7	4	28.7	4.22	-
AMC - Med Hold Det *	1,589	1,478	111	132	1,082.8	114	935.2	18	147.6	825.83	23
AMC - Total (Army)	2,747	2,526	221	172	816.2	158	749.7	14	66.5	322.52	20
AMC - Total (Air Force)	660	629	31	27	533.3	19	375.3	8	158.0	657.52	3
AMC - Total (A & AF)	3,407	3,155	252	199	761.4	177	677.2	22	84.2	387.21	23
Total - Dept/Army Units	20,250	18,419	1,831	632	406.8	567	365.0	65	41.8	54.01	21
Total-Dept/Air Force Units	4,593	4,515	78	111	315.0	98	278.1	13	36.9	105.93	3
*Army and Air Force personnel included											

\*Army and Air Force personnel included

ADMISSIONS, SPECIFIED DISEASES - RATE PER 1000 PER YEAR  
4-Week Period Ending 28 July 1950  
(Data from WD AGO Forms 8-122)

	Common Respiratory Diseases	Pneumonia All Types	Pneumonia Atypical	Influenza	Measles	Mumps	Scarlet Fever	Tuberculosis	Rheumatic Fever	Diarrheal Disease	Hepatitis	Malaria	Psychiatric Disease
Fort Belvoir (A)	146.7	-	-	-	7.6	15.3	-	-	3.1	-	3.1	1.5	-
(AF)	-	-	-	-	-	-	-	-	-	-	-	-	-
Fort McNair (A)	-	-	-	-	-	-	-	-	-	-	-	-	-
(AF)	-	-	-	-	-	-	-	-	-	-	-	-	-
Fort Myer (A)	64.3	-	-	9.2	-	9.2	-	-	-	-	9.2	-	-
(AF)	-	-	-	-	-	-	-	-	-	-	-	-	-
South Post, Fort Myer (A)	40.7	-	-	-	-	8.1	-	-	-	-	-	-	-
(AF)	-	-	-	-	-	-	-	-	-	-	-	-	-
US Army Dispensary (A)	26.3	-	3.8	7.5	-	7.5	-	3.8	-	-	-	-	-
The Pentagon (AF)	79.2	3.6	-	3.6	3.6	3.6	-	-	-	-	-	-	7.2
All Others (A)	-	-	-	-	-	-	-	-	-	-	-	-	-
(AF)	-	-	-	-	-	-	-	-	-	-	-	-	-
Total Mil Dist of Wash (A)	85.6	-	.7	2.2	3.7	10.4	-	.7	1.5	-	2.2	.7	-
(AF)	72.9	3.3	-	3.3	3.3	3.3	-	-	-	-	-	-	6.6
AMC - Med Det (Duty Pers)*	-	-	-	-	-	-	-	-	-	-	-	-	-
AMC - Med Hold Det *	-	-	8.2	-	-	-	-	8.2	-	-	-	-	24.6
AMC - Total (Army)	-	-	4.7	-	-	-	-	4.7	-	-	-	-	14.2
AMC - Total (Air Force)	-	-	-	-	-	-	-	-	-	-	-	-	-
AMC - Total (A & AF)	-	-	3.8	-	-	-	-	3.8	-	-	-	-	11.5
Total Dept/Army Units	74.0	-	1.3	1.9	3.2	9.0	-	1.3	1.3	-	1.9	.6	1.9
Total Dept/Air Force Units	62.4	2.8	-	2.8	2.8	2.8	-	-	-	-	-	-	5.7

\*Army and Air Force Personnel Included

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**RESTRICTED****PREVENTIVE MEDICINE****VENEREAL DISEASE**

Venereal Disease rate among units within the Military District of Washington increased during the July report period.

The rate for July 1950 was 19.36, an increase over the June rate of 11.28. A total of 26 cases were reported for the four week period ending 28 July 1950. Of this total 21 were reported by Fort Belvoir; 4 for All Others, and one for Fort McNair.

During the report period, white personnel incurred 19 of the reported number of cases, with a rate of 15.58 and 7 were incurred by Negro personnel, with a resulting rate of 56.67 per 1000 troops per annum.

In order to enable non-professional personnel to more intelligently understand the rates of cases to personnel on duty at each designated station, we have undertaken to report the number of cases per 1000 men for this report period (July) in addition to the rate per 1000 per annum which is not always clearly understood and is often misinterpreted.

Pertinent statistical tables and charts may be found on pages 18, 19, 20 and 21.

**NEW VENEREAL DISEASE CASES - EXCL EPTS - MAY, JUNE AND JULY 1950**

	Rate per 1000 per year	Rate per 1000 per year	Rate per 1000 per year	Cases per 1000 Troops
	MAY 50	JUNE 50	JULY 50	JULY 50
Fort Belvoir	9.16	21.99	32.09	2.461
Fort McNair	12.30	-	16.48	1.264
Fort Myer	-	-	-	-
South Post, Fort Myer	8.28	6.58	-	-
US Army Dispensary, Pentagon	-	-	-	-
All Others	-	-	30.96	2.375
Total Mil Dist Wash Units	5.92	11.28	19.36	1.485
Army Medical Center - Total	4.35	7.42	-	-
Total Dept/Army Units Mil Dist of Washington	5.69	10.75	16.74	1.283

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CHART 1

ADMISSION RATES BY MONTH, ALL CAUSES, COMMON RESPIRATORY DISEASE AND INJURY  
MDW RATE PER 1000 TROOPS PER YEAR

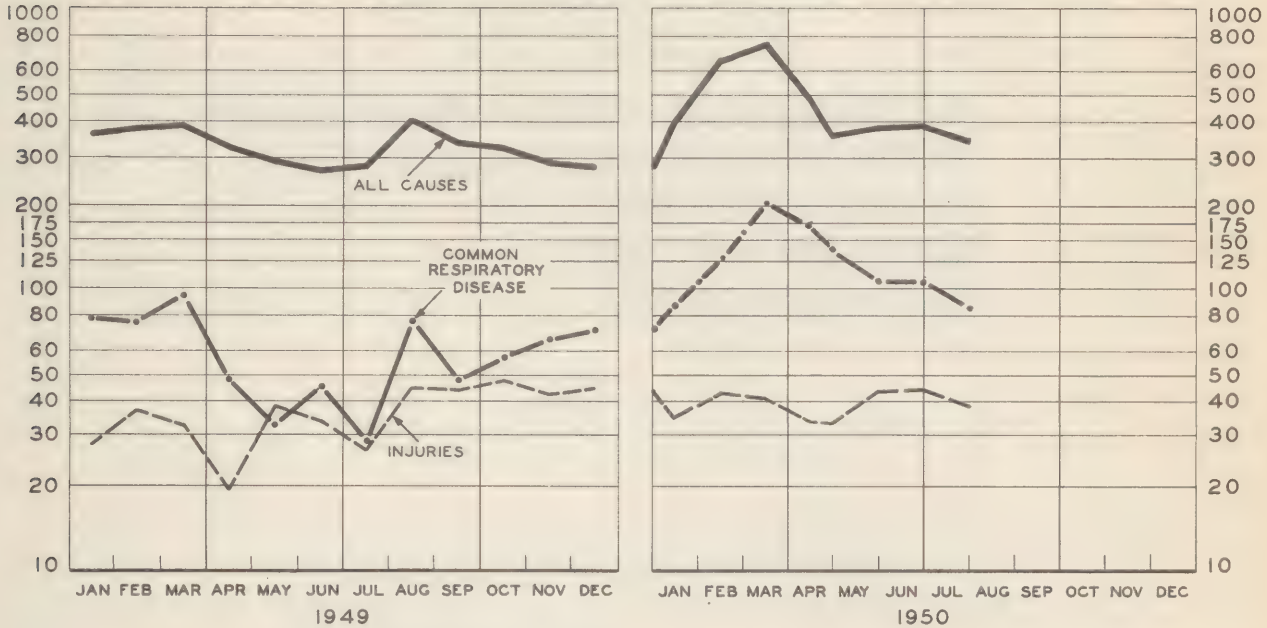
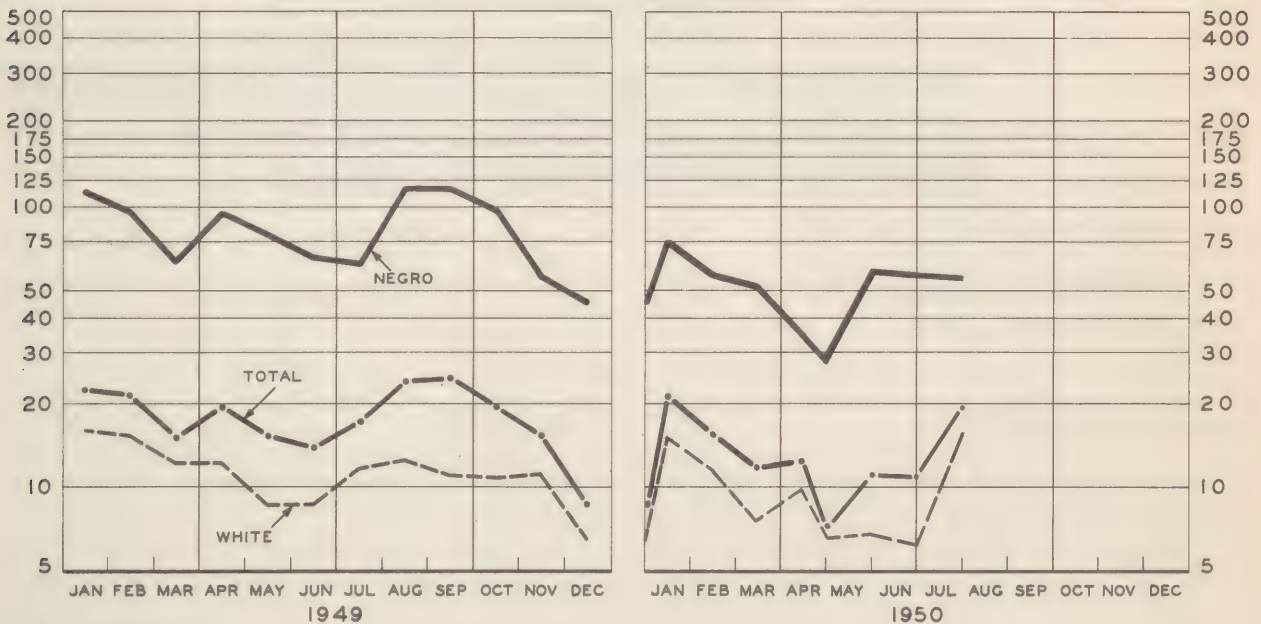
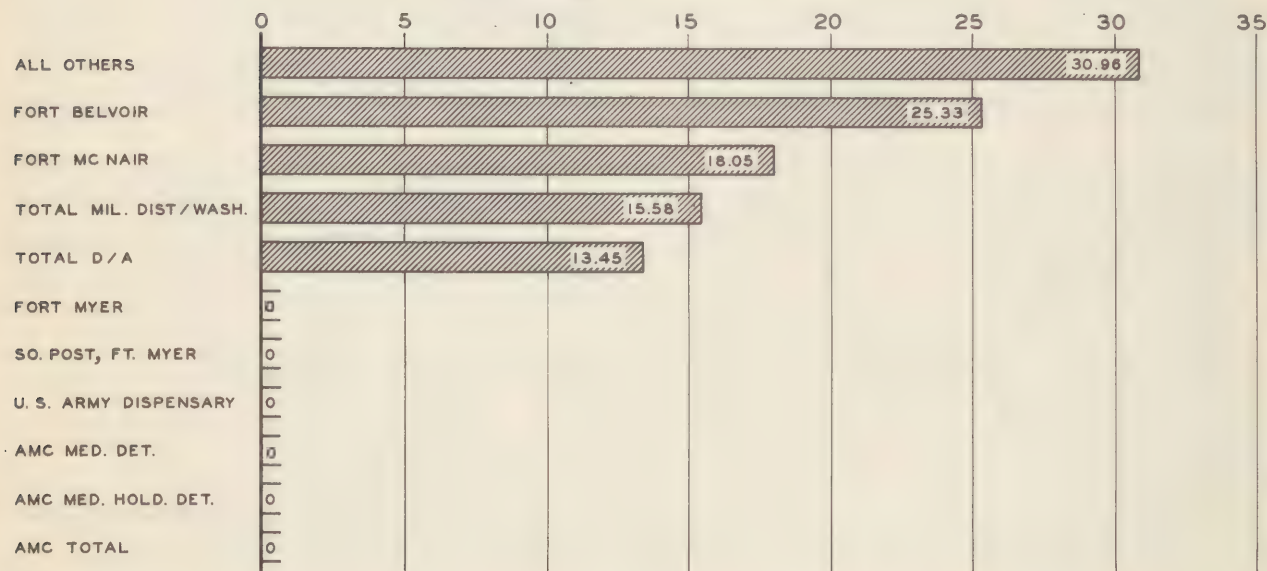


CHART 2

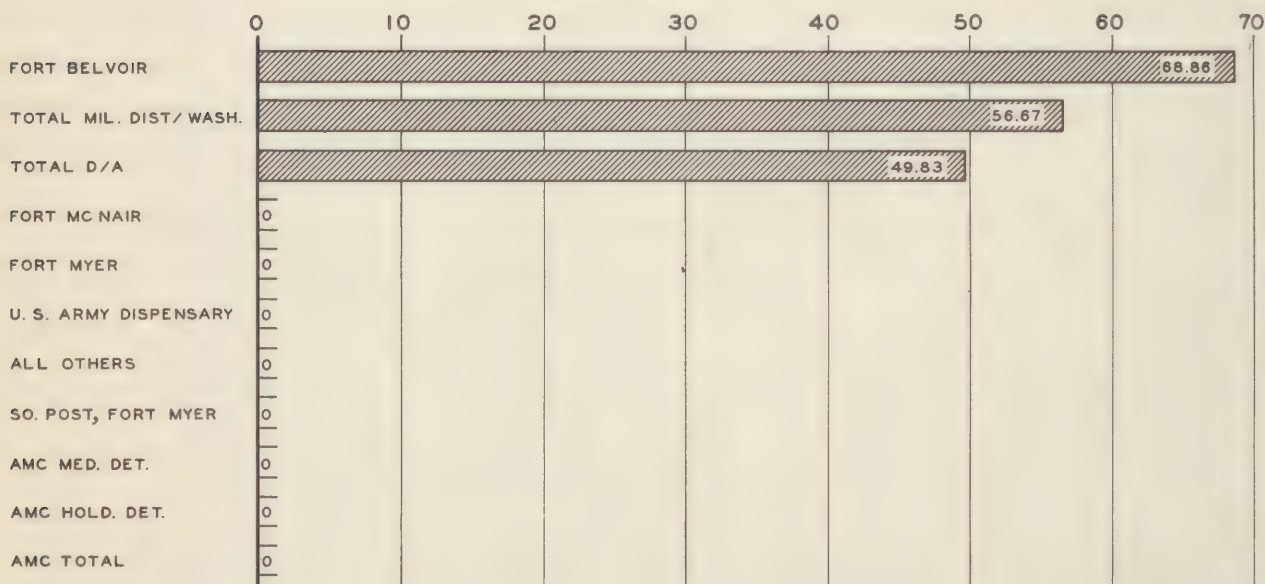
ADMISSION RATES BY MONTH VENEREAL DISEASES MDW INCL. ARMY MEDICAL CENTER  
RATES PER 1000 TROOPS PER YEAR  
INCLUDES ALL CASES REPORTED ON WD AGO 8-122 EXCEPTING THOSE EPTS



**VENEREAL DISEASE**  
**RATE PER 1000 TROOPS PER YEAR**  
**4 WEEK PERIOD ENDING 28 JULY 1950**  
**WHITE PERSONNEL (CHARGEABLE CASES)**



**VENEREAL DISEASE**  
**RATE PER 1000 TROOPS PER YEAR**  
**4 WEEK PERIOD ENDING 28 JULY 1950**  
**NEGRO PERSONNEL (CHARGEABLE CASES)**





# PREVENTIVE MEDICINE

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## VENEREAL DISEASE RATES FOR US\*

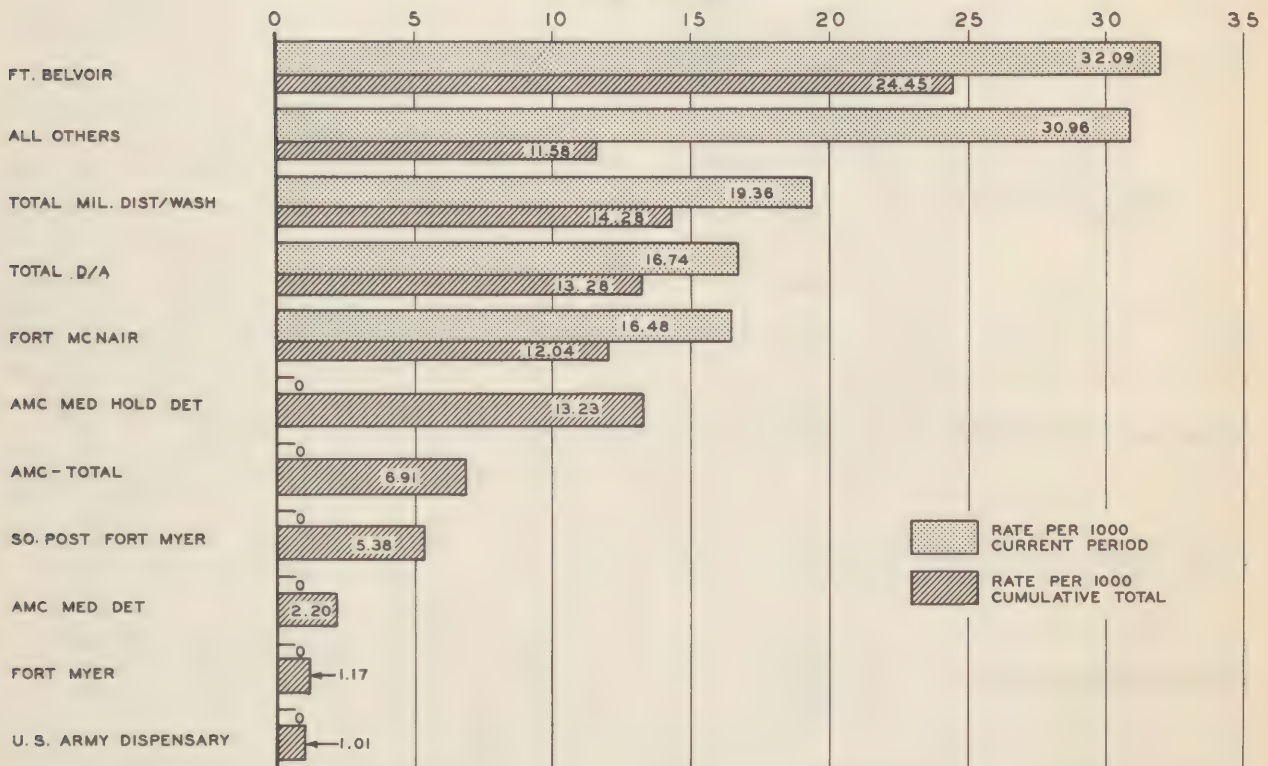
(All Army Troops)

	MAY 1950	JUNE 1950	JULY 1950
First Army Area	12	12	16
Second Army Area	14	17	21
Mil District of Washington	6	10	16
Third Army Area	23	20	24
Fourth Army Area	12	15	14
Fifth Army Area	13	10	13
Sixth Army Area	18	17	17
Total United States	15	15	18

\*Compiled in the Office of the Surgeon General and Included US Army Hospitals

## VENEREAL DISEASE RATES PER 1000 PER YEAR FOUR WEEK & CUMULATIVE TOTALS ENDING 28 JULY 1950 TOTAL WHITE & NEGRO PERSONNEL

(CHARGEABLE CASES)



**RESTRICTED**

**RESTRICTED****PREVENTIVE MEDICINE****CONSOLIDATED MONTHLY VENEREAL DISEASE STATISTICAL REPORT**

For the Four Week period ending 28 July 1950

(Data from WD AGO 8-122) (Chargeable Cases)

	R A C E	Mean Strength	Number of Cases-EPTS Not Included				Rate per 1000 Troops per Annum	Total Days Lost From Duty (Old & New Cases)
			Syphilis	Gonorrhea	Other	Total		
Fort Belvoir	W	7205	1	13	0	14	25.33	0
	N	1325	4	3	0	7	68.86	6
	T	8530	5	16	0	21	32.09	6
Fort McNair	W	722	0	1	0	1	18.05	0
	N	69	0	0	0	0	-	0
	T	791	0	1	0	1	16.48	0
Fort Myer	W	1238	0	0	0	0	-	0
	N	181	0	0	0	0	-	0
	T	1419	0	0	0	0	-	0
South Post, Fort Myer	W	1603	0	0	0	0	-	0
	N	-	0	0	0	0	-	0
	T	1603	0	0	0	0	-	0
U. S. Army Dispensary The Pentagon	W	3441	0	0	0	0	-	0
	N	35	0	0	0	0	-	0
	T	3476	0	0	0	0	-	0
All Others	W	1684	0	4	0	4	30.96	0
	N	-	0	0	0	0	-	0
	T	1684	0	4	0	4	30.96	0
Total Mil Dist of Wash	W	15893	1	18	0	19	15.58	0
	N	1610	4	3	0	7	56.67	6
	T	17503	5	21	0	26	19.36	6
Army Medical Center-Total	W	2526	0	0	0	0	-	56
	N	221	0	0	0	0	-	15
	T	2747	0	0	0	0	-	71
Total Dept/Army Units	W	18419	1	18	0	19	13.45	56
	N	1831	4	3	0	7	49.83	21
	T	20250	5	21	0	26	16.74	77



# VETERINARY SERVICE

**RESTRICTED**

## POUNDS MEAT AND MEAT FOOD AND DAIRY PRODUCTS INSPECTED JULY 1950 (Data obtained from WD AGO Forms 8-134)

	CLASS * 3	CLASS * 4	CLASS * 5	CLASS * 6	CLASS * 7	CLASS * 8	CLASS * 9	TOTAL
Fort Leslie J. McNair		55,635	86,870		159,220		37,553	339,278
Fort Belvoir, Virginia		341,552	257,385		624,770	116,141	221,272	1,561,120
Alexandria FBO		429,691	74,661	485,352			72,828	1,062,532
Fort Myer, Virginia		172,821	128,247	30	326,563	7,001	157,334	791,996
Cameron Station, Alexandria, Va.		120,061	98,775		249,620	5,885	66,203	540,544
Mil Dist/Washington Vet Det.	404,168							404,168
The Pentagon						257,458		257,458
TOTAL	404,168	1,119,760	645,938	485,382	1,360,173	386,485	555,190	4,957,096
<b>REJECTIONS:</b>								
Insanitary or Unsound								
Alexandria FBO		130						130
Mil Dist/Wash Vet Det.	4,380							4,380
Fort Myer, Virginia		240						240
Not type, class or grade								
Alexandria FBO		1,954						1,954
Mil Dist/Wash Vet Det	31,589							31,589
Fort Myer, Virginia		48						48
TOTAL REJECTIONS:	35,969	2,372						38,341

\*Class 3 - Prior to Purchase

\*Class 4 - On delivery at Purchase

\*Class 5 - Any Receipt except Purchase

\*Class 6 - Prior to Shipment

\*Class 7 - At Issue

\*Class 8 - Purchase by Post Exchange, Clubs

Messes or Post Restaurants

\*Class 9 - Storage

NOTE: The name of Potomac Yards Distribution Point has officially been changed to Alexandria Field Buying Office.

## DENTAL SERVICE

### DENTAL SERVICE - FOUR WEEK PERIOD ENDING 28 JULY 1950

	Military		Civilian		Sit- tings	Amal- gam	Oxy and AMal	Sili- cate	In- lays	Bridges	Bridge Repair	Crowns	Dentures		Re- pair	Extrac- tions	Calou- lus Removed	X-Rays	Exami- nations
	Men	Duty Days	Men	Duty Days									Full	Par- tial					
Fort Belvoir	6	175	1	19	1354	229	303	64	1	10	5	6	16	28	16	283	81	459	804
Fort McNair	2	50	-	-	396	266	132	21	-	3	2	-	2	8	2	44	35	137	92
Fort Myer, Va.	2	62	-	-	890	192	45	34	1	-	1	1	3	21	5	76	18	555	314
South Post, Fort Myer	2	40	-	-	149	83	56	15	-	1	1	2	-	2	2	15	11	114	43
US Army Disp	6	161	1	20	2333	500	138	145	1	4	13	5	10	21	6	71	204	691	1279
All Others	2	16	-	-	174	60	88	31	-	-	1	3	-	-	-	14	3	29	39
Total - MDW	20	504	2	41	5296	1330	762	310	3	18	23	17	31	80	31	503	352	1985	2571

## OUTPATIENT SERVICE

Consolidated statistical data on outpatient service, Military District of Washington, less Walter Reed Army Hospital, are indicated below for the four-week period ending 28 July 1950:

### ARMY:

Number of Outpatients . . . . . 3,289  
Number of Treatments . . . . . 14,983

### NON-ARMY:

Number of Outpatients . . . . . 5,116  
Number of Treatments . . . . . 16,306

NUMBER OF COMPLETE PHYSICAL EXAMINATIONS CONDUCTED . . . . . 2,050

NUMBER OF VACCINATIONS AND IMMUNIZATIONS ADMINISTERED . . . . . 7,193

## HOSPITAL MESS ADMINISTRATION

STATION	APRIL 1950	MAY 1950	JUNE 1950	JULY 1950
FORT BELVOIR				
Income per Ration	\$1.041	\$1.026	\$1.05	\$1.03
Expense per Ration	1.055	1.073	1.14	1.09
Gain or Loss	-0.013	-0.047	-.09	-.06

**RESTRICTED**



# DEPARTMENT OF DEFENSE

## CIVILIAN EMPLOYEES HEALTH SERVICE PROGRAM

### METROPOLITAN AREA OF WASHINGTON

THE CIVILIAN EMPLOYEE HEALTH SERVICE  
DEPARTMENT OF DEFENSE  
WASHINGTON METROPOLITAN AREA

Colonel Wesley G. Cox MC Consultant

Health is a dynamic state of physical well-being, of soundness in body, mind and spirit and of freedom from acute, chronic or degenerative disease. When attained and maintained, health is a priceless possession.

In 1946 the Congress of the United States provided for a health service for all Federal civilian employees by the passage of Public Law 658, 79th Congress (60th Stat). The civilian employee health service programs of the Army, the Navy and the Air Force developed separately during World War II were operated under the provisions of this Act after 1 July 1947.

This program is directed toward the maintenance of safe and hygienic working conditions; the development and maintenance of good health and the prevention of diseases and degenerative conditions among the Federal civilian employees of the Nation.

Under the provisions of memorandum, The Secretary of Defense to the Secretary of the Army, the Secretary of the Navy and the Secretary of the Air Force, the civilian health programs of three departments of the Department of Defense were consolidated as of 1 July 1950 into a single unified and coordinated service designated the Civilian Employee Health Service, Department of Defense, Washington Metropolitan Area.

The Director of the Office of Medical Services, with the advice and assistance of the Surgeon General of the military departments is responsible for the overall coordination and control of the Department of Defense civilian health program. The Department of the Army is responsible for the provision of approved health services for the civilian employees of the Department of Defense.

The objectives of the Civilian Employee Health Service, Department of Defense, Washington Metropolitan Area are:

- a. To insure that the employee is physically fit for the job to which he is to be assigned.
- b. To afford supervisory personnel and other management officials information required for the proper internal placement and utilization of employees.
- c. To provide emergency treatment for medical, surgical and dental emergencies.
- d. To assist all civilian employees in maintaining the optimum mental, psychological and physical state of health.
- e. To assist in the prevention of acute, chronic and degenerative diseases during the course of employment.

The objectives of the program are being accomplished through:

- a. Conducting pre-employment, periodic, and other types of health evaluation medical examinations.



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## CIVILIAN EMPLOYEES HEALTH SERVICE

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b. Maintaining an on-the-job emergency medical, surgical and dental service.

c. Maintaining safe and hygienic working conditions.

d. The practice of the principles of preventive medicine.

e. Referring to physicians and to hospitals, employees injured in the performance of duty or suffering from diseases proximal to employment in accordance with regulations and procedures governing the administration of the United States Employees' Compensation Act of 1916 as amended.

f. Referring to private physicians and dentists, employees who while on-the-job suffer from nonoccupational emergency illnesses or emergency dental conditions and who require further consultation and/or treatment.

The health service dispensaries previously operated by the departments of the Army and the Navy, at The Pentagon, the Main Navy Building, Arlington Annex, Bureau of Yards and Docks, Potomac Annex, Navy Department Services Center, Cameron Station, Army Map Service, Temp B, Temp 7, Armed Forces Institute of Pathology, and Army Service Unit 7005 have been designated as dispensaries and branch dispensaries of the Civilian Employee Health Service, Department of Defense, Washington Metropolitan Area.

### CIVILIAN EMPLOYEES' HEALTH SERVICE PROGRAM

by

Colonel Robert E. Bitner

Medical Director

Secretary of Defense, Mr. Louis Johnson, issued a directive to the effect that the health program for the civilians employed by the Armed Forces in the Metropolitan Area of Washington, would as of 1 July 1950, be consolidated and operated under the Department of the Army. The Surgeon General of the Army was designated responsible for technical and supervisory control. This was done because of a long experience gained in the operation of an Industrial Health Program, subsequently known as the "Army Industrial Medical Program", and as of 1 July 1950 re-designated the "Civilian Employees' Health Service Program".

Since there are many problems involved such as staffing, supply, budgeting, cost-accounting and maintenance of records which deal with the actual operation of the Civilian Employees' Health Service Program, it was necessary that an operating agency be delegated these functions. Since there is such an operating agency in the District of Columbia, namely, the Military District of Washington, the responsibility for operations of the Civilian Employees' Health Service Program for the Armed Forces, Metropolitan Area of Washington was delegated to the Commanding General, M.D.W.

The Commanding General of the Military District of Washington has designated the Surgeon, Military District of Washington, as the Medical Director of this program. Everyone is interested in a serviceable and efficient program. To accomplish this we need the cooperation of all. It will mean work, suggestions, tact and much "give and take".

A section of the Monthly Health Report, MDW, will be devoted to the Civilian Employees' Health Service Program. The Editor of this publication welcomes any article of a general interest.

Any article you desire to submit, forward it to the Medical Director, Room 2D-201, The Pentagon, Washington 25, D. C.

Everyone should feel free to communicate with the Office of the Medical Director and bring any matter to his attention.



## CIVILIAN EMPLOYEES HEALTH SERVICE

are: The dispensaries, their locations and the personnel assigned to duty at the present time

### Main Dispensary, Room 1E-356, Pentagon

Dr. Irma Bache, Chief Medical Officer  
Dr. Donald R. Sickler, Radiologist  
Dr. Charles P. Banfield, Medical Officer, General  
Dr. Alfred Baer, Medical Officer, General, (Part time)  
Dr. Andrew Tessitore, Medical Officer General, (Part time)  
Mrs. Margaret Rumsey, Chief Nurse  
Mrs. Mary Baker, Staff Nurse  
Miss Helen Braden, Staff Nurse  
Mrs. Annie Conwell, Staff Nurse  
Mrs. Barbara Meyers, Staff Nurse  
Miss Virginia Leftwich, Staff Nurse  
Mr. Ellsworth Downs, X-ray Technician  
Miss Lois M. Moss, Chief Clerk  
Mrs. Marian B. Webb, Clerk-steno  
Miss Kathleen Cook, Clerk-typist  
Mrs. Flora Brinkman, Clerk  
Miss Phyllis Horton, Clerk-typist  
Miss Beverly Hungerford, Clerk

### Dispensary, Tempo Building 7, Room 1074, Gravelly Point, Washington 25, DC

Mrs. Mable Jacobs, Staff Nurse  
Mrs. Kathryn Cornforth, Staff Nurse

### Main Navy Dispensary, Room 1511, Main Navy Bldg., 18th & Constitution Ave. Washington 25, D. C.

Dr. Joseph P. McMahon, Chief Medical Officer  
Mrs. Helen P. Anderson, Chief Nurse  
Mrs. Emily K. Allison, Staff Nurse  
Miss Patricia A. Boyle, Staff Nurse  
Mrs. Alfield M. Burton, Staff Nurse  
Miss Margaret A. O'Brien, Staff Nurse  
Mrs. Doris T. Specht, Staff Nurse  
Mrs. Evelyn L. Bailey, Clerk-typist

### Dispensary, Navy Arlington Annex, Room 2057, Arlington, Virginia

Mrs. Evelyn M. Stohlman, Staff Nurse  
Mrs. Virginia W. Blagman, Staff Nurse  
Mrs. Gertrude B. Cannon, Staff Nurse

### Dispensary, Bureau Yards and Docks, Room 1B-57, Washington 25, DC

Miss Sibyl Hammer, Staff Nurse

### Main Dispensary, Room 1E-356, Pentagon, Cont'd.

Mrs. Virginia Sansford,  
Hospital Attendant  
Mr. James Chatman, Chauffeur

### Emergency Room 2A-750, Pentagon

Mrs. Regina Glennon, Staff Nurse  
Miss Anne Lee, Staff Nurse

### Emergency Room 3A-750, Pentagon

Mrs. Pearl Beverly, Staff Nurse

### Emergency Room 4A-750, Pentagon

Mrs. Millicent Trivig, Staff Nurse  
Miss Ruth Samselle, Staff Nurse

### Dispensary, Tempo Building B, Room 1069, 2nd & R Sts., S.W., Washington, D.C.

Mrs. Ottilia Shoup, Staff Nurse  
Mrs. Nellie Dunn, Staff Nurse

### Emergency Room, Potomac Annex, Bldg 23, Rm. 12-A, 23rd & Constitution Ave. Washington 25, D. C.

Mrs. Lucille Erps, Staff Nurse

### Cameron Station, Warehouse #4 Alexandria, Virginia

Dr. Herbert Wisotsky, Medical Officer, General  
Mrs. Ruthe C. Halpin, Head Nurse  
Mrs. Katherine G. Updegrove, Staff Nurse

### Dispensary, Army Map Service, Bldg. 7, Room 213, Washington 25, D. C.

Dr. Herbert Wisotsky, Medical Officer, General (part time)  
Mrs. Florence Walton, Staff Nurse  
Mrs. Alma Caho, Staff Nurse  
Mrs. Grace Badgett, Clerk-typist(part time)

### Emergency Room, Army Map Service, Bldg. 1, Room 116, Washington 25, D. C.

Miss Orpha Tenseth, Staff Nurse

### Dispensary, Arlington Hall

Mrs. Marie Jackson, Staff Nurse  
Miss Erma Ganascioli, Clerk-typist